Dr. Leak: Welcome to the health care disparities podcast. This is our regular exploration of health equity. In part one of our podcasts, we discussed how a group of healthcare leaders in Florida worked collaboratively to create and implement the first community health needs assessment for the Jacksonville, Florida community. In addition to partnering to create their first community health needs assessment. They also work together to deliver a coordinated approach to health education for the community. In 2020, like all of us, our group of healthcare leaders were faced with the challenge of a pandemic. So let's rejoin the conversation as we explore ways that the collaborative framework that was established in Jacksonville help the group to work towards an equitable response to COVID-19.

Bill: One of the things that COVID brought out were the significant health disparities with regard to both hospitalization, mortality and just incidents. Did you find in your communities that that the same experience? Was there anything with regard to your collaborative efforts that perhaps allowed you to do a better job of dealing with the disparities related to COVID and was that at all helpful?

Ann-Marie: Yes. I'll jump in here, Bill, and thank you for asking that. I mean, you know, we know that race and other social determinants of health result in higher rates of illness and death among racial and ethnic minority

groups and the pandemic itself brought it even more to light of the evidence of this and the health disparities. We know that if one single organization or sector can't combat health disparities or help address health disparities and bring health equity alone, and that we really have to do it together. I'll just share an example of what we did last year. You know, the partnership has been, and is committed to being a part of the solution. An example of that is in early, probably mid-May of 2020, we held a list of misconceptions of COVID-19, which was very successful in the community. I think we had over 400 attendees that attended that session. Due to feedback from the session, we realized that there was a want and a need for additional opportunities to have these forums. Then in early summer we came together, like we naturally do, our partnership, outside of our CHNA priorities and said, what can we do for the community to continue this conversation? We developed a four-part racial equity conference series to increase awareness and understanding of the community at large, and for healthcare providers on racial factors that negatively impact the delivery of healthcare, where health disparities very much exist and kind of help break down those barriers.

So, we engaged with speakers and moderators outside of our healthcare institution. We didn't bring our speakers from our healthcare institutions, our medical professionals that could very easily talk about

this, but we pulled in local community leaders and national speakers to discuss these topics on the need to increase awareness and empowerment of our health. Some of these topics were advocating for your health, how does race impact health and what can be done to bring health equity, addressing a bias in healthcare and that unconscious bias and achieving health equity. Kind of next steps, right? What are the next steps? We're not going to stop there. Right? The attendance collectively from the four series was attending live at 800. We probably reached much more than that because there're over a thousand people that registered for collectively all four and I'm sure has been forwarded on with recordings. It concluded in 2020, but we know that we need to continue the work, but we made a commitment as our partnership, especially in our next community health needs assessment, that we would focus on health equity and sharing data and the health disparities that exist in our community.

Participant: I would like to give an example to that. So, before we had the COVID-19 vaccine, when we were facing flu season in 2020, and everyone was concerned. We don't know what the flu might bring to our community. We certainly know that if we have a flu season like we've had in the past, that means a lot of beds will be used, and we don't need that in the time of COVID. Also, they didn't know what the interaction might be between flu and COVID, so there was a huge push to get people

vaccinated. The Duvall County medical society took the lead and they put together a campaign which included the health systems as well as insurers, as well as other physicians, private practice physicians. Our role in the campaign was to help with the pharmacist to provide vaccine clinics in the community. So, exactly what Anne Marie said. Anne Marie had some great relationships in the community that none of our other health systems did. And so, she's the one who reached out to those folks and organized flu vaccine clinics. The same thing with Ashley, the same thing with Paul and the same thing with Jessica. We just sort of divided the map and identified who we knew, and we went to the relationships that we have, and we were quite successful with getting vaccine clinics across northeast Florida, where we were actually taking the flu vaccine to people, as opposed to requiring them to get out when it was still a scary time, particularly for our seniors and getting them vaccinated.

Bill: You talked about doing the education and outreach into the community about overcoming and understanding the disease and things of that nature. The second part of that and what I've seen is, so we go through that process and now we have the vaccines. How did any of that affect how you approached vaccine distribution? In other words, a lot of the attention was on, oh, we're going to do the elderly first, or we're going to do first responders or teachers or whatever, but what about the

vulnerable communities that during the lead up, during the testing and the diagnosis, we knew that there was a disproportionate impact. Did that translate into how you were going to distribute vaccines and say, we have these vulnerable populations. We need to focus on them as well, or was that not part of the conversation?

Participant: So, I would say initially, day one, I'm talking day one. The goal was just to get it out there. Our hospital was tapped to be the point to receive the vaccine first and spread it across the other hospitals in the city. I would say day one we were just, at least here, let's get it out there. Now, not far behind that, day two, we said, all right, let's look at the data. Let's look at who's the most vulnerable. We have approximately 5,000 patients that are the uninsured patients in our community. You know, so we clearly had an advantage to reach out to that population. So, we did some direct marketing and communicating with them. But to answer your question, really from the day one standpoint, we just knew we needed to get it out. We needed to get it, of course, in the hands of our colleagues so they could do their part and really spread it around the city. Just remember the geography of our hospitals, all of our hospitals were all over the city. So that was the first priority. As days proceeded, and even today as we work, [inaudible 08:38] health around vaccine hesitancy, we of course are being more targeted in who we are trying to communicate with.

Bill: And does that involve community-based distribution now? I mean, in the initial phase, and I think to the point you're raising, it was to get this out there and so there was a lot of focus on mass vaccination sites. You know, we were going to have it at a single location, and part of that was also, I think because of the storage requirements for some of the early, the Pfizer, for example. But now we're starting to see more community-based, smaller, targeted distribution administration. Is that how your market has evolved, your communities have evolved? That same kind of going from the mass distribution now out to more of a community-based distribution?

Ann-Marie: So, I mean, I can speak, but definitely my colleagues can chime in. Our hospitals are all giving the vaccine. The department of health is out there only at their fixed facilities, but we do have a FQHC, Agape, that has a mobile unit that partnered with our local transportation organization, the Jacksonville Transportation Authority, and they are actually beating the neighborhoods, so to speak, and doing that community based. I think it's statewide or federal, we have these sites that came in around our city. So, the way the hospitals really looked at it is, we got the FEDs here with us who've helped us with geography. We have the mobile colleagues out there. So, for the most part, unintentionally or not, the hospitals have really stepped back and kept

the vaccine at the hospital level and pushed to our patients because our patients represent the city. So, if we can get our patients all vaccinated and their family members, we are at the forefront of that vaccination opportunity.

Participant: Yes. I mean, I was going to bring up the same point, Ann Marie, about our federally qualified health care clinics that are out there really into the communities and neighborhoods and providing those, and federal was a lot that came in to help with the influx in addition to the state. But I think I want to backtrack just a little bit and Ann Marie alluded to it briefly. Initially, we wanted to get it out to people, look at our most vulnerable, look at those high risk folks. But I think that piece of it too, is looking at our most vulnerable, looking at the health disparities at our racial and ethnic minority groups is that there's a lot of mistrust in healthcare. So, we have the vaccine, it's available but the question was also if it's available to people, are people going to get it? So, I think that was a focus from each of our healthcare systems. What are the concerns of our community members? What are the myths and misconceptions that are out there? I mean, social media is great, but it can be toxic at times too, because there's misinformation that gets out there about it. For example, at Mayo Clinic, we participated with community partners. Our enterprise wide was Arizona and Rochester, where we did a four-part series of vaccine hesitancy, the myths and

misconceptions, minority racial and ethnic groups. We did one in Spanish to have more of a conversation from the community with our providers to ask questions about it, because you could have it out there, but if people still have those myths and misconceptions in their head, are they really going to get it. I know other hospital systems, we partnered with several of the hospitals systems to help with healthcare executives to get the information out there as well. So, I just wanted to bring that up too, is that that was a big focus for all of us to try to address the hesitancies.

Melanie: I just wanted to make a comment too. I think all of us experienced a sense of urgency and of course, some of that was because of the devastation of the disease. And so, we wanted people to be vaccinated as soon as possible. We also had mandates from our state that we had to work within and we were getting pressure from the state level to get people vaccinated, get people vaccinated. And so, Bill, I think that's what led to a lot of what you described as these mass vaccination clinics, these sites that can vaccinate hundreds of people in a day, a thousand people in a day. So, the way we at Baptist Health tried to address underserved populations, of course, keeping within the governor's mandate, is in partnership with the community organizations we work with. So, we reached out to them and said, can you help us get the word out that we have vaccines available? Then we partnered with

Ann Marie mentioned them before, Jacksonville Transportation Authority. They stepped up. That organization said, we want to do whatever we can to make sure people do not have any problem getting to a vaccine site and then getting back home. And so, they reached out to our partners and provided transportation from our partner organizations to our mass vaccination clinic and then back again. So, it really was, I would say, a community effort. You know, COVID was something that it doesn't matter what your logo is on the side of your building or on your vehicle. Everyone had to address this because it was killing all of us and it had a disproportionate impact as well. So, we really felt this urgency to do whatever we could to make a difference.

Participant: I think it seems like such a simple thought, but I think it really is complicated in how it's implemented, but we really have open transparent conversation, this among many things. So as Melanie said, and Ann Marie, people were doing these COVID vaccination sites. We really at Ascension St. Vincent, just really did not have the opportunity to go into the community with vaccinations, but what we could do to support was get the word out. We have a very well-connected vast faith community network and Baptist does, too. Mayo is an east side, Emory, New Town, Springfield. There's so many of us kind of embedded in those specific communities that we can communicate. We can share that information. This was the most important public health initiative that

we could all support. It was all hands on-deck. And many of us were at those toted vaccination sites doing paperwork, helping to support, getting people in just that process. So, what we could do to support is rather than in a clinical way, was that open communication and that support to get word out.

Dr. Leak: Absolutely. And hearing the experiences of our collaborative and partnership team members still, I'm reminded of what I keep hearing every day on the news and that's the lack of a coordinated approach in public health across the country. And here we have this very well-established partnership, really focused on public health that laid the foundation and they continue to, well, how should I say, expand upon, leverage, grow those relationships. And no one could have envisioned a pandemic, right? But to have that model, that process, that trust, those significant resources already in place where you could pull levers and come together to address this unprecedented need in the community is quite remarkable and inspirational.

Bill: It is. So, my curiosity now is, we're not through with the pandemic, obviously. I think hopefully we're well into closer to the end. But a critical next step, as I see it is an after-action report to go back and say, what did we do right? What didn't we get right? What can we do to make sure? Because while the pandemic may have taken us by

surprise, I think we have to presume that it's only a matter of time before there's another pandemic or another type of event along these lines. So, do you guys have plans or would you anticipate some kind of a collaborative after-action analysis and then recommendations for what to do to be better prepared the next time something like this occurs?

Ann-Marie: I actually think some of that happens of course amongst us, but I think some of our colleagues in our practices are doing that already. So, for example, supply chain, right? Our pharmacies are all talking to each other about the inventory of vaccine and how to distribute and so forth.

Participant: And our emergency rooms.

Ann-Marie: Oh, yes. The emergency room. We all are in an HR state of being right now where we're all struggling with staffing. So, our HR partners. So, I wouldn't want us to feel like we're the only ones at the game. We have a lot of partners across our institutions that, you know, maybe Jacksonville is unique, you know? But they all talk. All of our subject matter experts, across our institution talk, and I can guarantee, despite the fact that I'm guessing, I can guarantee that our colleagues, I know they've been talking, but I know they are going to continue. I suspect they will continue those conversations.

Bill: Yes. Unfortunately, I'm not as optimistic as you that this kind of collaboration and conversation is occurring in other communities.

Dr. Leak: But what an example that we can share with the world and with the country. And you all have provided this absolutely fabulous opportunity for that sharing and learning quite broadly. We have a pretty significant audience for Movement is Life. So, we are pleased to partner with you and promote this and the work that you have done. I am going to thank each of you as we close the session. It's just been our pleasure to have this unique opportunity to hear about this unique work and model and collaborative that you had put together and sustained in Jacksonville and as a member of this community, you're making a difference. We see it, we hear it every day. So, thank you so very, very much. We really appreciate your time.

Bill: Thank you.

Dr. Leak: Thank you guys. Bye-bye.

This concludes our two-part series on collaborative health needs assessment. Thank you to our panelists once again, and thank you, our listeners for joining us for another episode of The Health Disparities

Podcast. We hope you have already subscribed to our podcast on iTunes and will join us again. I'm Michelle Leak saying goodbye for now.

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